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Judges sharply challenge healthcare law

Skeptical questions from three federal judges in Atlanta suggest they may be ready to declare unconstitutional all or part of the healthcare law promoted by the Obama administration and passed last year by Congress.

By David G. Savage, Washington Bureau

4:24 PM PDT, June 8, 2011

Reporting from Atlanta

If the Obama administration had any doubt that its signature healthcare law faces a severe challenge in court, it was erased soon after Chief Judge Joel Dubina opened the proceedings here.

"I can't find any case like this," Dubina said. "If we uphold this, are there any limits" on the power of the federal government?

Judge Stanley Marcus chimed in: "I can't find any case" in the past, he said, where the courts upheld "telling a private person they are compelled to purchase a product in the open market.... Is there anything that suggests Congress can do this?"

After nearly three hours of argument Wednesday, the three-judge panel of the 11th Circuit Court of Appeals seemed prepared to declare at least part of last year's law unconstitutional.

The law's requirement that nearly everyone buy health insurance by 2014 is the question at the heart of the constitutional challenge. The argument that the mandate exceeds Congress' power initially was waved aside by many legal commentators, but it has now sharply divided the federal courts.

Three federal district judges have upheld the law and two have ruled it unconstitutional. Three cases have reached appeals courts, with a fourth appellate panel scheduled to hold a hearing in September.

The current case has gathered the most attention because it involves 26 state attorneys general — all Republicans — who jointly challenged the law. In addition, the 11th Circuit is considered among the most conservative of the federal appellate courts. If any of the appeals courts strikes down the law, the case almost certainly would land at the Supreme Court, perhaps during the election year. The 11th Circuit has been seen by legal experts as one of the more likely to rule against the administration.

The questions from the bench quickly confirmed that advance billing, as acting U.S. Solicitor Gen. Neal

Katyal faced off against former Bush administration Solicitor Gen. Paul Clement. Katyal argued that healthcare was unique and unlike the purchase of other products, like vegetables in a grocery store.

"You can walk out of this courtroom and be hit by a bus," he said, and if an ill or injured person has no insurance, a hospital and the taxpayers will have to pay the costs of his emergency care.

Katyal argued that Congress could reasonably decide that because everyone will probably need medical care at some time in their lives, everyone who can afford it should pay part of the cost. And he said the courts should uphold the law under Congress' broad power to regulate commerce in this country.

Congress could clearly require that a person who shows up at a hospital without insurance buy it on the spot, he said, and requiring the purchase in advance should not be the decisive difference.

Clement said, "In 220 years, Congress never saw fit to use this power, to compel a person to engage in commerce."

Judge Frank Hull, the third member of the appellate panel, repeatedly asked the lawyers about the possible effect of striking down the mandate while upholding the rest of the law. She said the government had exaggerated the importance of the mandate because other provisions of the new law would mean that most of the 50 million people currently without insurance would be covered after the law took effect.

Usually, when passing a complex law, Congress includes a provision known as a severability clause that says that if one part of the law is struck down, the rest can stand. The House included such a provision in its healthcare bill, but it was not included in the Senate version. And in the last-minute scramble, the House adopted the Senate's version.

Both sides agreed that the court faced an all-or-nothing decision.

Katyal called the individual mandate the cornerstone of the law's aim to regulate and reform the insurance market. The law requires insurers to take patients with preexisting conditions. That rule could not work if people could wait to buy insurance until they had a heart attack or were diagnosed with cancer, he said.

Clement also said the judges should strike down the entire law. "You can't separate out the mandate. We take the position the whole thing falls," Clement said.

In addition to the argument over the law's individual insurance mandate, the appeals court also considered a challenge by the states to the requirement that they pay more in the future for healthcare for low-income people under Medicaid. That part of the new law amounts to an unconstitutional burden foisted on them by Congress, Clement argued.

Clement said Congress gave the states "no choice" but to go along with the expansion of Medicaid. He said Florida estimated it would spend $574 million more in 2019 because of the expanded rolls.

The Medicaid claim has not won any support from other federal judges, but Dubina said the states had "a pretty strong argument" they were being forced to pay millions of dollars more to enroll low-income residents.

Administration lawyers say the law calls for the federal government to pay 90% of the added costs of enrolling additional Medicaid patients. They also note that the Supreme Court has never struck down a

law on the grounds that it forces states to do something in exchange for federal funds.

Judicial rulings on the health law have largely been along partisan lines. Dubina, from Alabama, was first appointed to the bench by President Reagan and was elevated to the appeals court by President George H.W. Bush. His daughter, Rep. Martha Roby of Alabama, is a conservative Republican who ran for office on a pledge to repeal the healthcare law.

Hull, from Georgia, was appointed by President Clinton. The third member of the panel, Marcus, from Florida, was first appointed as a district judge by Reagan, but Clinton appointed him to the appeals court.

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FOR IMMEDIATE RELEASE
May 31, 2011

Contact: HHS Press Office
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HHS to Reduce Premiums, Make it Easier for Americans with Pre-Existing Conditions to Get Health Insurance

The U.S. Department of Health and Human Services (HHS) today announced new steps to reduce premiums and make it easier for Americans to enroll in the Pre-Existing Condition Insurance Plan. Premiums for the Federally-administered Pre-Existing Condition Insurance Plan (PCIP) will drop as much as 40 percent in 18 States, and eligibility standards will be eased in 23 States and the District of Columbia to ensure more Americans with pre-existing conditions have access to affordable health insurance. The Pre-Existing Condition Insurance Plan was created under the Affordable Care Act and serves as a bridge to 2014 when insurers will no longer be allowed to deny coverage to people with any pre-existing condition, like cancer, diabetes, and asthma.

"The Pre-Existing Condition Insurance Plan changes lives, and in many cases, literally saves lives," said HHS Secretary Kathleen Sebelius. "These changes will decrease costs and help insure more Americans."

In 23 States and the District of Columbia, the PCIP program is Federally-administered. The remaining States operate their own PCIP programs using Federal funds provided by the Affordable Care Act.

Under the changes announced today, PCIP premiums will drop as much as 40 percent in 18 States where the Federally administered PCIP operates. These premium decreases help bring PCIP premiums closer to the rates in each State's individual insurance market; in the six States where PCIP premiums were already well-aligned with State premiums, premiums will remain the same.

The changes announced today will make enrolling in the Federally-administered PCIP in 23 States and the District of Columbia easier. Starting July 1, 2011, people applying for coverage can simply provide a letter from a doctor, physician assistant, or nurse practitioner dated within the past 12 months stating that they have or, at any time in the past, had a medical condition, disability, or illness. Applicants will no longer have to wait on an insurance company to send them a denial letter. This option became available to children under age 19 in February, and this pathway is being extended to all applicants regardless of age. Applicants will still need to meet other eligibility criteria, including that they are U.S. citizens or residing in the U.S. legally and that they have been without health coverage for six months.

HHS also sent letters today to the 27 States running their own programs to inform them of the opportunity to modify their current PCIP premiums.

To further enhance the program, beginning this fall, HHS will begin paying agents and brokers for successfully connecting eligible people with the PCIP program. This step will help reach those who are eligible but un-enrolled. Several States have experimented with such payments with good success. This is a part of continuing HHS outreach efforts with States, insurers, providers, and agents and brokers to reach more eligible people and let them know that coverage is available. HHS is also working with insurers to notify people about the PCIP option in their State when their application for health insurance is denied.

Congress created the temporary PCIP program as part of the Affordable Care Act to help uninsured Americans with a variety of medical conditions get affordable coverage rather than be locked out of the system by insurance companies. In 2014 and beyond, insurers will be prohibited from denying coverage to anyone with a pre-existing condition and new competitive marketplaces called Health Insurance Exchanges will give people the opportunity to shop for the policy that best suits their needs. Millions of Americans also will receive tax credits to help make coverage affordable.

Enrollment in PCIP programs has begun to grow rapidly. In the period between November 2010 and March 2011, enrollment in all programs rose 129 percent to more than 18,000 Americans enrolled in PCIP.

"These changes will get more people covered," said Steven Larsen, the Director of the Center for Consumer Information and Insurance Oversight. "We're encouraged by recent increases in enrollment and we're excited to build on these efforts and reach even more people."

PCIP provides comprehensive health coverage, including primary and specialty care, hospital care, prescription drugs, home health and hospice care, skilled nursing care and preventive health and maternity care. It limits annual out-of-pocket spending and does not carve out benefits the people need. Eligibility is not based on income and people who enroll are not charged a higher premium because of their medical condition.

To find a chart showing changes to PCIP premiums in the States with Federally-administered PCIP programs, visit www.HealthCare.gov/news/factsheets/pcip05312011a.html.

For more information, including eligibility, plan benefits and rates, as well as information on how to apply, visit www.pcip.gov and click on "Find Your State." Then select your State from a map of the United States or from the drop-down menu. The PCIP Call Center is open from 8 a.m. to 11 p.m. Eastern Time. Call toll-free 1-866-717-5826 (TTY 1-866-561-1604).

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Note: All HHS press releases, fact sheets and other press materials are available at http://www.hhs.gov/news.

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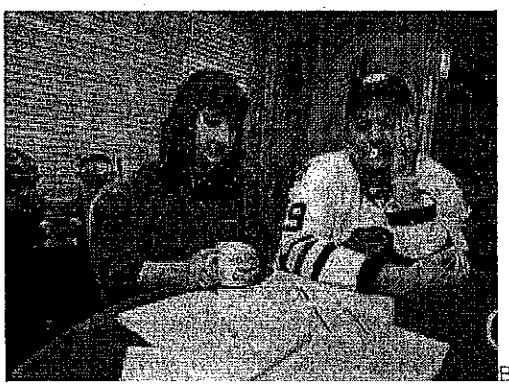
High-deductible insurance plans are gaining popularity

Updated 5/31/2011 1:09 PM |

By Kelly Kennedy, USA TODAY

WASHINGTON — Last year, Tina Holwin Hodges' healthy family switched to a high-deductible health insurance plan and were able to save $100 a month on their monthly premiums, which seemed like a bargain.



By John Zich, USA TODAYTina and Chris Hodges of Portage, Ind., look at a stack of medical bills they racked up because of the high deductible on their insurance.

Enlarge

By John Zich, USA TODAY

Tina and Chris Hodges of Portage, Ind., look at a stack of medical bills they racked up because of the high deductible on their insurance.

Then her daughter Cailee spent three days in the hospital with a viral infection, her d aughter Heather went in for a cardiac workup, her husband had hand surgery after being out of work for a year, and she injured her back and couldn't work for three months. Hodges found that her family plan with a $2,400 deductible and a $11,900 maximum on out-of-pocket spending was too much of a burden. Rather than paying a $20 co-pay per visit to the doctor, her family paid 20% of each visit until they reached their deductible.

"It was the unexpected stuff that got us," she said.

This year, Hodges, who works as a nurse at a Chicago hospital, and her family have opted into a traditional, low-deductible plan.

STORY: Feds now target top execs in health frauds

"I went back to the HMO," she said. "The high-deductible plan really didn't help me."

In 2007, about 4.5 million people had high-deductible plans, but by 2010, 10 million people had signed up for the plans, according to an America's Health Insurance Plans survey of its members.

High deductibles

In exchange for a high deductible — a maximum $3,000 deductible for individuals and a $6,000 deductible for families, for instance — people can save about $85 to $100 a month on premiums.

"People are choosing higher deductibles for lower premiums," said Karen Ignagni, president of America's Health Insurance Plans, which represents 1,300 companies providing health insurance to more than 200 million Americans.

It's important that they understand those lower premiums can mean higher doctors' bills, she said.

Yet in a RAND Corp. study released in April, researchers found that even as health care costs continued to rise, people on high-deductible plans paid substantially less than did those on traditional plans.

RAND researchers also found that people on high-deductible plans — no matter their income level — received less preventive care: fewer annual exams, fewer cervical cancer screenings and fewer colonoscopies.

Studies have shown that people don't know that their plans waive fees for preventive care, researcher Amelia Haviland wrote in the report.

Some may skip exams

Last year, Dorie Griggs, a communications and faith consultant based in Roswell, Ga., purchased a high-deductible plan because she works freelance and the high-deductible plans were cheaper. Griggs has a cavernous hemangioma — or dilated blood vessels — in her brain that must be monitored every year with an MRI. Because the test is expensive — from $1,500 to $4,000, depending where a person lives — she decided to get the scan every two years.

She also put off a colonoscopy.

"Our insurance out-of-pocket is more than our mortgage every month," Griggs said.

Haviland theorized that people may not seek preventive exams because they fear what other expenses might surface during those exams. For example, a colonoscopy may lead to the removal of a polyp.

"This is where you cross your fingers and hope nothing goes wrong," Griggs said.

The federal health law passed in 2010 has addressed some of those issues: Beginning last September, most high-deductible health insurance plans must include basic preventive care, such as colonoscopies and annual physicals.

And the law also includes subsidies for low-income families, as well as an end to benefits caps. Experts worry that still won't address

all of the problems.

Patients should shop

Christopher Parks, chief executive officer of Change:healthcare, said unexpected expenses — such as a hospital stay for a viral infection, as well as simply not knowing how much a procedure costs, can lead to unpaid bills.

Change:healthcare supports these plans because they force consumers to look at costs, which may, in turn, bring down prices.

People don't tend to ask how much a service will cost because in the past, Parks said, the bill went straight to the insurance company.

His company has found that something as simple as a child's sports physical can run anywhere from $29 at a retail clinic to $160 at a primary care physician's office, so it's important to shop around.

Some people simply don't have the money, and Parks said health care organizations have had to write off millions of dollars because people in high-deductible plans did not understand when they went in to see the doctor what the end cost would be, and then could not pay their bills.

Employers like the plans because it's cheaper to insure an employee — about $133 less per family at companies that offer only the high-deductible plans, according to a study in the American Journal of Managed Care.

They found that 47% of people insured through their employers have high-deductible plans.

Parks said the number of employers offering only high-deductible plans will continue to increase.

Parks said the plans could decrease health care costs, but only if people begin asking how much services cost and comparison shop.

A service of the California HealthCare Foundation

California Healthline
The Daily Digest of News, Policy & Opinion

May 26, 2011 - The Think Tank

Where Do Brokers Fit in New Health Insurance Picture?

California's health insurance regulations -- aligned this year with federal guidelines -- include a requirement that insurers spend at least 80% of their premium revenue on direct patient care. However, efforts to change provisions of the federal Patient Protection and Affordable Care Act could have an effect on how California insurers balance their books -- and on how consumers pay for health coverage.

Previously operating on a 70-30 split, California adopted the 80-20 ratio in January to be in line with new federal guidelines. But precisely what is contained in the two portions is being contested. The 20% not used for direct medical care includes profit and administrative costs -- including insurance broker fees.

The House is considering a bill (**HR 1206**) that would exempt insurance brokers' fees from being classified as administrative costs. After it was introduced by Reps. Mike Rogers (R-Mich.) and John Barrow (D-Ga.), the bill attracted more than 50 co-sponsors.

Some consumer advocates argue that the ACA is already a boon to the insurance industry, bringing in millions of new policy buyers. They say not counting broker commissions as part of administrative costs in the medical loss ratio could take the financial teeth out of reform.

Even using the term "medical loss ratio" could be construed as an indication the ACA is written from an insurer's -- rather than a consumer's -- point of view, according to some. The term suggests that 80 cents of every dollar spent on medical care for a patient is considered a "loss" by the insurance industry.

The National Association of Insurance Commissioners voted to postpone taking a position on the bill. Some state commissioners support the bill, and some oppose it.

In California, a related effort is under way: **AB 736**, by Assembly member Chuck Calderon (D-Montebello), would allow health insurance agents to also be licensed health insurance brokers.

We asked experts and stake holders: How should Congress handle the issue? What is the potential effect on California if HR 1206 passes? What are the potential effects if HR 1206 fails?

We got responses from:

- Lynn Quincy and Betsy Imholz, Senior policy analyst and special projects director, Consumers Union
- Janet Trautwein, CEO, National Association of Health Underwriters
- Judy Dugan, Research director, Consumer Watchdog
- Elizabeth Abbott, Director of administrative advocacy, Health Access California
- Neil Crosby, Vice president, public affairs, California Association of Health Underwriters

Broker, Agent Pay Should Stay in MLR

Lynn Quincy and Betsy Imholz
Senior policy analyst and special projects director, Consumers Union

The Affordable Care Act aims to keep health insurers accountable by establishing a national "medical loss ratio" requiring them to spend at least 80% of the premiums they collect on patient *medical* care. Up to 20% can be used to cover administrative expenses, brokers' and agents' fees, and profits. Under the ACA, insurers that don't spend at least 80% on medical care must provide rebates to consumers.

The California Department of Insurance adopted this federal standard earlier this year. A bill pending in the state Senate, **SB 51**, would apply it to plans licensed by the Department of Managed Health Care, too.

But now there's a move afoot at the National Association of Insurance Commissioners and in Congress -- **HR 1206** -- to water down the MLR standard by allowing insurers to take agent and broker commissions out of the equation. Doing so would make it appear that insurers are spending more on medical care than they actually are and would impede efforts to control administrative costs.

Since the early 1990s, insurers have spent a decreasing percentage of premiums on medical care. To improve value for consumers, several states, including California, had MLR regulations in place for many years. These states include broker and agent compensation in the calculation of administrative costs. They report that brokers and agents thrive under these regulations, casting doubt on claims that the MLR regulations will severely undermine brokers' incomes and their ability to serve consumers.

Evidence shows that the new MLR rules are beginning to hold down premiums for consumers. Aetna, for example, is asking the Connecticut Insurance Department for permission to cut rates on nearly 10,000 existing individual health policies by an average of 10% in order to comply with the new MLR requirements.

Brokers and agents can provide a valuable service to many consumers and small-business owners. But the compensation they receive from insurers should be counted as part of the MLR, as our country struggles to address soaring health care costs. Otherwise, insurers will be able to get away with spending less than 80% of the premiums they collect on medical care.

Misguided War on Insurance Agents

Janet Trautwein
CEO, National Association of Health Underwriters

Earlier this month, the federal government announced that unemployment has barely budged in the last two months. More than 13 million people remain out of work. And yet several consumer advocates are leading the charge in support of a provision of the federal health care law that could eliminate scores of jobs throughout the country.

At issue is the law's "medical loss ratio," which requires insurers to spend at least 80% to 85% of the premiums they take in on medical claims. Fortunately, several lawmakers and the National Association of Insurance Commissioners are considering a job-saving tweak to the health care law that would exclude brokers' commissions when calculating the MLR.

Without the fix, thousands of insurance agents and those who work at their agencies would be consigned to the unemployment lines -- thereby depriving consumers of valuable advocates in the health care marketplace.

The MLR requirement is deeply unpopular. Eight states have now requested waivers from the new rules; Maine just received one. All these states are concerned that the regulations will disrupt their insurance

markets by driving small insurers that can't afford to comply out of business.

In Maine, for instance, one of the state's three active insurers threatened to pull out of the market unless the state received a waiver. Such a move would have left Maine residents with just two choices for insurance -- and by reducing competition, would have driven up prices.

The MLR rules may disrupt state insurance markets in another way -- by depriving consumers of access to licensed agents and brokers.

In order to abide by the rules, some insurers are paring back agents' commissions. According to a recent survey, nearly three-quarters of agents have reported reductions in their business income because of the MLR. More than a fifth of brokers have eliminated jobs at their agencies as a result. A quarter have reduced services for their clients in order to make ends meet.

That's bad news for small businesses, many of which depend on agents to take care of their health insurance needs. In fact, the nonpartisan Congressional Budget Office has reported that agents and brokers often "handle the responsibilities that larger firms generally delegate to their human resources departments -- such as finding plans and negotiating premiums, providing information about the selected plans, and processing enrollees."

Small firms also count on brokers to keep them in compliance with a veritable alphabet soup of state and federal laws -- and informed of any opportunities to save money on their plans.

Individual consumers will also suffer if they lose access to agents. Most consumers are unfamiliar with the jargon that may dot their policies -- and thus rely on their brokers to explain their benefits and serve as advocates on their behalf should problems arise.

Proponents of the reform law's existing MLR rules argue that broker commissions should count as administrative costs because they are not medical spending. But the truth is far more complicated.

Broker commissions are actually separate from an individual's or business's insurance premium. They're not revenue for an insurance company, as they simply pass through the insurer and go directly back to the agent. It's a matter of convenience for consumers. Rather than writing two checks -- one to the insurer for coverage and one to the agent for serving as an advocate -- a person or firm writes just one.

Many lawmakers have recognized that the MLR rules must be fixed in order to preserve agents' important role in the health care marketplace. Reps. John Barrow (D-Ga.) and Mike Rogers (R-Mich.) have introduced a bill in the House of Representatives that would fix the MLR rules to leave commissions out of the calculation. Their measure has attracted support from Republicans and Democrats alike.

The Obama administration has championed itself as a friend of small businesses, calling them "the backbone of our economy and the cornerstones of our communities." But the MLR rules undermine that claim. By driving scores of insurance agencies to the brink of bankruptcy -- and killing scores of small-business jobs in the process -- the MLR rules are making the health insurance marketplace even less accessible for everyone else.

Congress Should Support Modest Consumer Protection

Judy Dugan
Research director, Consumer Watchdog

If the health insurance industry steamrolls HR 1206 through Congress, insurance brokers will get permanent income protection and a shield for their aging business model. Insurers will be freed of pressure from federal health reforms to operate efficiently or curb excessive profits. Consumers will be stuck with new premium increases and lose more than $1 billion in annual rebates.

The Affordable Care Act requires that insurance companies spend 80% to 85% of customers' premiums on

health care. It was a modest consumer protection to begin with. Most large-group policies already meet the 85% goal. Several states already require medical loss ratio requirements near the 80% level for small-business policies, with no ill effects on markets. The ACA was only copying the best practices of states.

Broker commissions have long been part of insurers' marketing and administrative costs. HR 1206 would deduct broker commissions from insurer administrative costs for the purpose of measuring the medical loss ratio. Insurers could then simply raise premiums to pay brokers and not worry about the 80% and 85% medical loss ratios.

Regulations adopted after passage of the ACA already allow insurers and HMOs to deduct federal and state taxes from administrative costs, as well as count other former administrative costs as medical care. An independent actuary's report this February found that the concessions will give Anthem Blue Cross of California an extra 4% boost in its MLR. A 76% MLR will magically become 80% -- a lot of slack not envisioned by Congress when it said insurers should spend at least 80 cents of every premium dollar on medical care.

If broker pay is also deducted from administrative costs, insurers will get another false boost in their MLR -- about 5% to 6% in the individual and small-business markets, according to drafts of a study by the National Association of Insurance Commissioners. Consumers would lose most of the $1.4 billion insurers are expected to owe in rebates this year. The cost to taxpayers -- because of federal subsidy requirements -- is likely to be tens of billions of dollars.

Brokers complain that insurers are slashing their commissions because of the federal MLR requirement, and this will cause of shortage of brokers. However, Minnesota currently requires loss ratios of 82% or above in most of the small-business market, and it reports not a single complaint about scarcity of broker assistance. Kansas says in about two-thirds of its market, insurers already hit the 80% mark.

A requirement that, as of 2014, everyone must show proof of insurance will bring brokers millions of potential new customers. If they adapt to online markets and become more efficient, they can thrive without HR 1206. Keeping brokers prosperous is not consumers' responsibility.

The bottom line: Congress has no business guaranteeing yesterday's income to brokers and continued high profits to insurance companies out of the wallets of taxpayers and battered health care consumers.

California consumers may get a double whammy. Proposed state legislation, also sponsored by the brokers' lobby -- **AB 736**, by Assembly member Chuck Calderon (D-Montebello) -- would eliminate broker premiums from insurer's administrative costs and also cancel the requirement that brokers enter contracts with insurers they represent. Therefore, AB 736 would erase insurance companies' accountability for errors or omissions by brokers who sell their policies. Insurers would have no reason to ensure that brokers selling their policies told the truth.

Goal Is To Spend Less on Bureaucracy, More on Care

Elizabeth Abbott
Director of administrative advocacy, Health Access California

As one of the dozen or so national consumer representatives chosen by the National Association of Insurance Commissioners to represent the consumers' viewpoint, I was heavily involved in the complex negotiations with the industry and state regulators on the medical loss ratio. While we did not win every argument over the seven months and hundreds of hours of conference calls when this was under discussion in 2010, we believe NAIC achieved a good regulatory compromise through its open, transparent and participatory process.

However, currently agents and brokers object to their compensation being counted as an "administrative expense," as Congress clearly saw it when drafting the Affordable Care Act. While the brokers and agents believe they provide a valuable service to purchasers, their principal argument is that it will result in a

potential loss of income. And brokers and agents represent a potent political constituency in many states as is reflected in a bill, by Rep. Mike Rogers (R-Mich.), before Congress that would result in the exclusion of brokers' and agents' compensation from the MLR calculation altogether.

Some state insurance commissioners wanted NAIC to quickly endorse the bill to exclude the commissions. Other insurance commissioners, including California's Dave Jones, urged caution and sought more information before amending the previous NAIC position on brokers' compensation. We urged that NAIC establish an evidence-based re-examination of the effect of the change to the MLR on the costs and access to agents.

NAIC ultimately asked for more data from associations, insurers and state regulatory agencies that reflect similar changes, particularly in those states that had a similarly high MLR standard before the enactment of federal health reform. It is hard to maintain that the reason brokers' and agents' compensation has been declining for more than a decade is solely a reflection of the MLR regulation that went into effect in January 2011. NAIC is deferring a policy decision regarding the Rogers bill until that process is completed.

Consumer representatives believe that deleting brokers' compensation from the MLR would dismantle a key consumer protection that allows patients to know their premiums are going to care, rather than administration and profit. These late attempts to amend the MLR would weaken the provisions that provide for greater efficiencies and cost containment included in the ACA.

The goal of the MLR requirement is to get insurers to spend less money on bureaucracy and more on health care. Consumers benefit if efficiently run small insurers stay in the market and if a variety of types of plans remain available, providing competition for the big plans and for national commercial insurers. The current MLR regulation, certified by HHS, recognizes and balances the claims of the various interests that fully participated in its drafting. We recommend it not be changed.

Agents, Brokers Offer Essential Services

Neil Crosby
Vice president, public affairs, California Association of Health Underwriters

If I remember correctly, the original goal of health care reform was to gain control of and lower the spiraling costs of health care. When momentum and support waned for the proposed health care reform bill, the Obama administration pivoted to health insurance reform.

By the time the Patient Protection and Affordable Care Act was passed and enacted, the provisions the administration had advocated to lower health care costs seemed to have vanished. What we are left with are provisions that attempt to hold down health care costs by enforcing rate/premium control.

One of these such provisions is the medical loss ratio, which says that insurers must spend 80% of premiums on medical care and are therefore allowed to spend only 20% on administrative costs. This provision no more addresses the underlying rising cost of health care than if Congress were to address rising gas prices by limiting gas stations on how much they can charge at the pump.

One of the costs within the administrative portion of premiums is compensation for agents and brokers. Through this provision, the professionals that employers count on each day as their "benefits" advisers are being squeezed, and it is affecting their ability to provide their service. Many employers reported that they use their agent/broker extensively. Many smaller employers say that they use their agent/broker to handle many functions for them that larger employers accomplish with an HR department, and that their agent/broker keeps them informed and in compliance on the many new provisions, as well as existing laws.

In California, an individual has more than 100 plans available to them, and small employers have more than 400 plans available. I have yet to find one employer or individual who would prefer to figure out on their own which plans fit their needs, the needs of their employees and the needs of their employees' families. Agents

and brokers also help the insured work through the complicated claims process.

Agents and brokers truly act as the consumer's advocate each and every day to help their clients and the public find what plans fit their needs, provide education and assist with compliance, and act as the insured's representative when issues arise, as they seem to do.

The House of Representatives is considering **HR 1206**, which would exempt agent/broker compensation from being included in the MLR provision. This proposed legislation has bipartisan support, and if enacted, would help to secure the essential services of agents/brokers for individuals and employers, their employees and families, as their advocates throughout California and America.

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Prevention: The Answer To Curbing Chronically High Health Care Costs (Guest Opinion)

TOPICS: HEALTH COSTS, PUBLIC HEALTH, HEALTH REFORM, POLITICS

KENNETH THORPE, PH.D., AND JONATHAN LEVER, Executive director of the Partnership to Fight Chronic Disease and vice president for health strategy and innovation at the YMCA of the USA

MAY 24, 2011

View all previous columns »

While Congress tries to control health care spending, lawmakers should be careful to make choices that are pennywise but not pound foolish.

In April, the House voted 236 to 183 to repeal the health law's prevention and public health trust fund. Republicans said they opposed giving the Secretary of Health and Human Services wide discretion on how to spend this money. But the result is a setback for the first dedicated source of funding for national prevention efforts and could be a missed opportunity to reduce spending even further by preventing the largest driver of health care costs -- chronic disease.

Largely preventable and highly manageable chronic diseases account for 75 cents of every dollar we spend on health care in the U.S. In contrast, we spend less than 5 cents on prevention, even though the World Health Organization and the Centers for Disease Control and Prevention have estimated that 80 percent of heart disease and type-2 diabetes, and 40 percent of cancers, could be prevented by doing three things: exercising more, eating better and avoiding tobacco.

Yet, we are headed in the other direction. One in five adults still smoke and one in two adults -- and a tragically large number of children -- are overweight or obese. Without a dramatic change, a third of American adults will have diabetes by 2050 (up from 1 in 10 today). Obesity already accounts for 10 to 20 percent of the rise in health care spending and obese adults cost 35 percent more than their normal-weight counterparts because of their risks for diabetes, high blood pressure and other related chronic conditions.

The status quo is expensive, but our future on the current course is unsustainable.

The silver lining is that we have evidence that we can prevent the onset and progression of diseases, including diabetes. These are exactly the types of efforts that the prevention fund should be used to support.

Case in Point: The YMCA, in facilities throughout the country, is offering a group-based diabetes

prevention program modeled after the landmark National Institutes of Health /CDC Diabetes Prevention Program. The NIH initiative proved that, with modest weight loss, it is possible to reduce the risk of developing type 2 diabetes among those with pre-diabetes by nearly 60 percent. So far, the YMCA's effort has been getting similar results, at costs that are dramatically lower than that of the NIH program. And the Y has scaled this program to communities in more than 20 states. Investing in the prevention fund could add the program to even more communities throughout the country.

Given that $1 out of every $10 spent on health care is related to diabetes and that people with diabetes have medical costs 2.3 times higher, preventing diabetes is a bargain. In fact, enrolling at risk adults aged 50 in this type of program could reduce the chance they would develop diabetes from 85 to 65 percent.

The NIH diabetes program is just one of the many evidence-based prevention programs vital to preventing chronic disease and curbing rising health care costs if made available nationally. It exemplifies how prevention works to not only improve health, but also to lower cost. Yes, Congress should be working to reduce costs, but lowering health care costs long-term depends on addressing what drives those costs – diabetes and other chronic diseases. We have to make the investment in the ounce of prevention to realize the pound of cure.

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THE COMMONWEALTH FUND

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How Pre-Existing Insurance Plans Are Helping to Bridge the Coverage Gap

When fully implemented, the Affordable Care Act will prohibit insurers from denying coverage to individuals because of preexisting health conditions. However, this provision of health reform will not go into effect until 2014. In the meantime, the law created Pre-Existing Condition Insurance Plans (PCIPs), state-based, temporary high-risk pools that make health insurance coverage available to individuals who have been unable to obtain it because of their health status or conditions.

A new issue brief from The Commonwealth Fund, by Jean Hall and Janice Moore of the University of Kansas, examines PCIP enrollment trends, benefits and premiums, and out-of-pocket costs. Enrollment has been more modest than expected, with approximately 21,000 people enrolled as of April 30, 2011, but the PCIP program is of critical importance, the authors say. By providing a temporary safety net for the "uninsurable," PCIPs have allowed thousands of people to get the care they need and prevented some people's conditions from progressing to disabilities. Recent federal and state reductions in premiums and deductibles will help make the plans more affordable.

Read the brief, part of the Realizing Health Reform's Potential series, to learn more about how PCIP plans are helping to bridge the coverage gap until health insurances exchanges are operational.

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